EXTENSIONS OF REMARKS

TRIBUTE TO JUDGE DAVID E. RUSSELL

HON. ROBERT T. MATSUI

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 2, 2000

Mr. MATSUI. Mr. Speaker, I rise in tribute to Judge David E. Russell, Chief Bankruptcy Judge of the United States Court of Appeals for the Eastern District of California. After 14 years as a Bankruptcy Judge and 40 years of service in the legal profession, Judge Russell has announced his retirement. He will be honored at a retirement party on Friday, November 3, 2000 at the Tsakopoulos Library in Sacramento. As his friends and family gather to celebrate, I ask all of my colleagues to join with me in saluting his remarkable career.

David E. Russell was born on March 19, 1935 in Chicago Heights, Illinois. He was married on October 31, 1982 to Sandra Niemeyer, and they are the proud parents of seven children.

He began his education at the University of California at Berkeley, graduating in 1957 with a Bachelor of Science in Accounting. He went on to obtain his Jurisprudence Doctorate from Boalt Hall, University of California at Berkeley in 1960.

David Russell began his career as an accountant for Lybrand, Ross Brothers and Montgomery in San Francisco, CA. Here he stayed for three years, during which time he was admitted to the California Bar in 1961. In 1965, he became a partner with Russell, Humphreys and Estabrook. Later to be known as Russell, Jarvis, Estabrook and Dashiell, he continued to work with the firm as a lawyer until 1986.

In 1986, David Russell was appointed to a 14-year term as a United States Bankruptcy Judge. In those 14 years, Judge Russell has developed a reputation as a fair and honest man, and he has served his appointment admirably. I am honored to have the opportunity to congratulate Judge Russell as he begins his well-deserved retirement.

Mr. Speaker, as Judge David Russell's friends and family gather to celebrate his retirement, I would like to take this opportunity to pay tribute to a truly remarkable person. His career with the United States Court of Appeals has indeed been commendable. I ask all of my colleagues to join with me in wishing him continued success in all his future endeavors.

MINORITY HEALTH AND HEALTH DISPARITIES RESEARCH AND EDUCATION ACT OF 1999

SPEECH OF

HON. ROBERT A. UNDERWOOD

OF GUAM

IN THE HOUSE OF REPRESENTATIVES

Tuesday, October 31, 2000

Mr. UNDERWOOD. Mr. Speaker, I would like to express my support of S. 1880, the Health Care Fairness Act of 2000. As an original co-sponsor of H.R. 3250, the House companion measure, I have long-supported legislation to expand research and education on the biomedical, behavioral, economic, institutional, and environmental factors contributing to health disparities in minority and underserved populations.

I would like to commend my colleagues, Representatives CLYBURN, LEWIS, THOMPSON, JACKSON, RODRIGUEZ, ROYBAL-ALLARD, and Senator EDWARD KENNEDY, who have worked long and hard to get this bill to the floor.

In recent years, advances in the prevention, diagnosis, and treatment of disease has improved the health status and quality of medical care to the overall U.S. population. However, while we are experiencing remarkable improvements in the health status of the overall U.S. population, we find this has not translated into similar benefits for minority populations. In fact, minority populations continue to experience disproportionate rates of disease, morbidity, and mortality. Numerous studies have proven that race and ethnicity correlate with persistent, and often increasing, health disparities among U.S. populations. These alarming disparities deserve our focused attention and call for action.

The passage of the Health Care Fairness Act would, for the first time, focus research and attention to health disparities such as those that exist in Guam, with the creation of a National Center on Minority Health and Health Disparities within the National Institutes of Health to conduct research on minority health problems and commission the National Academy of Sciences to conduct a comprehensive study of the data collection systems and practices of the Department of Health and Human Services. S. 1880 would also establish pilot projects in medical schools to develop educational tools that will reduce racial and ethnic health disparities. These improvements will increase our knowledge to the nature and causes of these disparities, as well as improve the quality and outcomes of health care services to minority and underserved populations.

As the Chairman of the Congressional Asian Pacific American Caucus and a member of the Congressional Hispanic Caucus, I am keenly aware of the health care needs of minority communities. Particular needs regarding language and cultural competency are often not being met in our public health centers and hospitals.

On the island of Guam, Chamorros, who are the indigenous population, and other Asian and Pacific Islander groups represent a large majority of the 150,000 population. With an island largely comprised of minority populations, it is challenging to meet specific health needs of our diverse community with the limited resources that are currently available. In the case of Chamorros, diabetes affects Chamorros at five times the national average and infant mortality rates are more than double the national average. Chamorros also suffer from higher than average rates of cardiovascular disease, cancer, and Lytico-Bodig, a disease endemic to Guam, which is a combination of Parkinsonian dementia and amyotrophic lateral sclerosis. The case of mental illness is also a great concern to Guam residents with rising incidences of attempted and completed suicides.

The overall Asian Pacific American population is often mislabeled as the ''model minority'' with few health or social problems. This is a huge misnomer as emerging data reveals significant health disparities and barriers to health care and social service access exist within Asian Pacific American communities. As a group, Asian Pacific Americans experience the highest incidences of tuberculosis. Particular Asian Pacific Americans sub-population groups experience diabetes, hepatitis B, cervical cancer, liver cancer, lung cancer, nasopharyngeal cancer, and mental illness at alarming rates. Recognizing the challenges presented by the great diversity of Asian Pacific Americans and other minority populations is key to addressing the health care needs of all Americans.

The Asian Pacific American population includes indigenous and immigrant populations, which comprises 10.4 million Americans or approximately 5 percent of the U.S. population. Asian Pacific Americans represent the fastest growing and most diverse racial and ethnic group in the U.S. with more than 30 different sub-populations and are expected to reach 10 percent of the U.S. population by 2050. Approximately 20 percent of Asian Pacific Americans are currently uninsured.

It is clear that the face of America is becoming increasingly diverse as its minority populations continue to grow. And as our minority populations increase, so does the complexity of our health needs. Therefore, I urge your support of S. 1880, the Health Care Fairness Act, to develop programs and comprehensive strategies to address the health disparities among ethnic and minority groups. This bill represents a comprehensive bi-partisan effort to address the inequities in health care for all Americans.

● This ''bullet'' symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.